ROBERT J. THOMPSON, Ph.D.
Clinical Psychologist

Child and Family Information Form

Date__________________

1. Who referred you for psychological services? ____

2. Name of child ________________________________ Child likes to be called________________

3. Date of Birth_________ Age _______Grade____ Ethnic/cultural identification________________

4. FEMALE PARENT LIVING IN THE HOME
   Name ____ Age: _______

   Occupation and Employer__________________________________
   Circle one: birth parent step live-in adoptive other

5. MALE PARENT LIVING IN THE HOME
   Name ____ Age_______

   Occupation and Employer__________________________________
   Circle one: birth parent step live-in adoptive other
6. If parents are married how long?_____________
7. Has either parent been previously married? YES NO
8. If child is not living with a birth parent, how much contact does he have with him or her?
   ____

9. Daytime phone number___________________ Evening phone number___________________

10. Please list child's siblings and anyone else who lives in the home:

Name	Age	Relationship to Child
________________________	__________	_________________________
________________________	__________	_________________________
________________________	__________	_________________________
________________________	__________	_________________________

11. What issue brought you to see me?

    ____

12. Please describe your child's strengths:
    ____

    ____

Please bring a copy of your child's most recent grades and any school or psychological testing

DEVELOPMENTAL HISTORY

1. Pregnancy: Planned Unplanned Birth weigh:________________

2. During the pregnancy, did the child's mother smoke, drink alcohol or use drugs:

   _____ Not at all _____ Some _____ A great deal

3. Problems during pregnancy: YES NO Birth complications: YES NO
   If YES, please describe:____

4. Describe any difficulties as an infant, or small child:

   ____

5. Developmental milestone – indicate approximate age:

   Walked alone: ________________
   Said first word: ________________
   Spoke sentences: ________________
   Bladder trained: ________________
   Bowel trained: ________________

6. Please check which apply to your child during his/her infancy and toddlerhood:

   _____ Easy going vs. _____ Demanding

   _____ Slept easily vs. _____ Difficulty sleeping

   _____ Easy to discipline vs. _____ Difficult to discipline

   _____ Approaches others easily vs. _____ Slow to warm up to others

   _____ Active, intense vs. _____ Slow, mellow

SCHOOL/DAYCARE

1. Is your child experiencing school/day care difficulties? YES NO
2. Are you concerned your child may have a learning disability? YES NO
3. Has your child received any special services at school e.g. special ed, speech, counseling?
4. If yes, explain:____
5. Child's school:____
6. Child's day care:____
7. Teacher's Name:____
8. School phone number:________________
9. If you or your child are currently involved with the principal or school counselor, please list name:____
10. Please list phone number, address and zip codes of the school/day care if you think I might need to contact them.____

MEDICAL BACKGROUND

1. Name of child's physician:________________________________

2. Has your child seen him/her recently? YES NO

3. Do you have any concerns about your child's vision, hearing, or speech? YES NO

4. Do you have any concerns about your child's eating/diet, sleeping, bladder/bowel habits? YES NO

5. Do you have any concerns about any other physical or medical problems your child may have? YES NO

6. Describe any concerns you have in the above questions:

   ____

7. Is your child taking any medications currently? YES NO
   If yes, what medication & dose: ____
   Does your child have any known allergies to medication? YES NO

Please check if your child has had any of the following diseases or conditions:

______Trouble with bladder or bowels
______ Allergies
______ Ear infections
______ Head injury, unconsciousness, seizures, meningitis
______ Chicken pox, mumps, measles, pneumonia
______ Broken bones or other significant injuries
______ Uncoordinated, awkward
______ Operations, hospitalizations

8. General comments about your child's health:____________________________________

9. List names of doctors, clinics, or agencies where your child has received care (e.g., doctors, welfare, speech therapy, previous mental health treatment, etc.)

____

____

10. Are there any significant health problems in the family? YES NO
    If yes, please describe:____

11. Do you have any suspicion that your child is involved in drug or alcohol abuse? YES NO

12. Do you have any knowledge or suspicion that your child was abused physically or sexually? YES NO

FAMILY HISTORY

1. Have there been any changes in the last year in your family, such as the following:

Moves	No_____	Yes____
Marital difficulties	No_____	Yes____
Change in health of family members	No_____	Yes____
Pregnancy, birth, adoption	No_____	Yes____
Parental work changes	No_____	Yes____
Serious injury, illness or accidents	No_____	Yes____
Separation of child from a parent	No_____	Yes____
Change in schools	No_____	Yes____
Loss of friends	No_____	Yes____
School failure, graduation	No_____	Yes____
Changes in daily routine	No_____	Yes____
Death of someone important	No_____	Yes____

2. Have there been other changes, significant events or unusual stressors that may have effected the family? YES NO

3. Has anyone else in the family had previous mental health treatment? YES NO

4. Does anyone in the family have a problem with alcohol or drugs? YES NO

5. Has anyone in the family had difficulty with the law? YES NO

6. Feel free to further describe any YES answer or any situation that might be impacting the problem now:____

    ____

7. Is religion an important part of your family? YES NO
8. If so which denomination? ________________________

9. How much contact does the family have with the extended family?
10. Circle one: none some a great deal

11. What questions do you hope to have answered and/or what do you hope to accomplish in our work together?

    ____

    ____

    ____

REGISTRATION FORM

PATIENT'S LEGAL NAME ____
First Last Middle Initial

Address ____ Apt. ___________

City ______________________ State ________ Zip ________ e-mail____________________

Home Phone ____________ Birth Date ___/___/___ Sex: [ ]M [ ] F

Patient's Primary Care Physician (PCP)____________________________________

Name of person who referred you to Dr. Thompson:______________________________

MOTHER ____
First Last Middle Initial

Birth Date_____/_____/_____

Address ***if different from Patient***____

City__________________ State________ Zip________ Home Phone_____________

Employer____________________________________ Work Phone_____________

FATHER ____
First Last Middle Initial

Birth Date_____/_____/_____

Address ***if different from Patient:***____

City__________________ State________ Zip________

Employer____________________________________ Work Phone_____________

PRIMARY INSURANCE

Subscriber ____/____/______________________
Subscriber Birth Date Relationship to Patient

Insurance Company:________________________________Insurance Phone Number:____________

Claim Address:____

ID #______________________Group #__________________ Effective Date _____/_____/______

SECONDARY INSURANCE

Subscriber ____/____/______________________
Subscriber Birth Date Relationship to Patient

Insurance Company:________________________________Insurance Phone Number:____________

Claim Address:____

ID #______________________Group #__________________ Effective Date _____/_____/______

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CONSENT TO TREATMENT

I have read, understood, and agree to these policies and procedures, including my rights, and/or my child's rights to confidentiality and its exceptions.

I hereby authorize Robert J. Thompson, Ph.D. and/or his billing service to release any medical/psychological information necessary to process claims with any insurance company. I also assign Robert J. Thompson, Ph.D. all payments to which I am entitled for medical expenses. I understand that my portion of payment is due at the time of service and that I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee.

- ☐ I have checked into preauthorization and insurance requirements and benefits for mental health services.

I give my consent to treatment and/or the treatment of my child.

____
Signature

____
Name of Patient

____

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Receipt and Acknowledgment of Notice of Privacy Practices and Service Agreement

Patient Name:____

I have received and have been given an opportunity to read a copy of Dr. Thompson's Notice of Privacy Practices. I understand that if I have any questions regarding my privacy rights, I can contact Dr. Thompson.

____
Signature of Patient, Parent or Guardian Date

❑ Patient, Parent or Guardian **Refuses** to Acknowledge Receipt of Privacy Practices Agreement
Date:____________________